P A R T S

HOSPICE

PART S
Hospice Services
Transmittal Log

This log is a convenient record sheet for recording receipt of handbook replacement pages. Delete old pages and insert new pages as instructed. Use this log to help eliminate errors and ensure an up-to-date handbook.

Each set of Part A handbook replacement pages is numbered sequentially. This sequential numbering system alerts you to any missing sets of handbook replacement pages. For example, if the last transmittal number on your log is S-3 and you receive S-5, you are missing S-4. You may obtain copies of *complete* provider handbooks by completing the order form in Appendix 36 of Part A of the Wisconsin Medicaid Provider Handbook.

Transmittal Number	Initials	Issue Date
S-1		06/92
S-2		12/92
S-3		10/93
S-4		07/01/92

Transmittal Number	Initials	Issue Date

INTRODUCTION

The Wisconsin Medical Assistance Program (WMAP) is governed by a set of regulations known as the Wisconsin Administrative Code, Rules of Health and Social Services, Chapters HSS 101-108, and by state and federal law. These regulations are interpreted for provider use in two parts of the WMAP provider handbook. The two parts of the handbook are designed to be used in conjunction with each other and with the Wisconsin Administrative Code.

Part A of the WMAP handbook includes general policy guidelines, regulations, and billing information applicable to all types of providers certified in the WMAP. The service specific part of the handbook includes information on provider eligibility criteria, covered services, reimbursement methodology, and billing instructions. Each provider is sent a copy of the Part A and appropriate service specific part of the handbook at the time of certification.

Additional copies of provider handbooks may be purchased by writing to the address listed in Appendix 3 of Part A of the WMAP Provider Handbook.

When requesting a handbook, be sure to indicate the type(s) of service provided (e.g., physician, chiropractic, dental).

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of WMAP policy and billing procedures.

NOTE: For a complete source of WMAP regulations and policies, the provider is referred to the Wisconsin Administrative Code, Chapters HSS 101-108. In the event of any conflict in meaning between HSS 101-108 and the handbook, the meaning of the Wisconsin Administrative Code will hold. Providers may purchase HSS 101-108 from Document Sales at the address indicated in Appendix 3 of Part A of the WMAP Provider Handbook.

Providers should also be aware of other documents, including state and federal laws and regulations, relating to the WMAP:

- Chapter 49.43 – 49.497, Wisconsin Statutes.
- Title XIX of the Social Security Act and its enabling regulations, Title 42 – Public Health, Parts 430-456.

A list of common terms and their abbreviations appears in Appendix 30 of Part A of the WMAP Provider Handbook and also in the Wisconsin Administrative Code, Chapter HSS 101.

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A. TYPE OF HANDBOOK

Part S, Hospice, is the service specific portion of the Wisconsin Medical Assistance Provider Handbook. Part S includes information for providers regarding provider eligibility criteria, recipient eligibility criteria, covered services, reimbursement rates, and billing instructions. Part S is intended to be used in conjunction with Part A of the Wisconsin Medical Assistance Program (WMAP) Provider Handbook, which includes general policy guidelines, regulations, and billing information applicable to all types of providers certified in the WMAP.

B. PROVIDER INFORMATION

Provider Eligibility and Certification

Hospice providers are required, under HSS 105.50, Wis. Admin. Code, to be certified to participate in Medicare as a hospice under 42 CFR 418.50 to 418.100.

The attending physician must be individually certified as a physician in order to bill the WMAP. Hospices which wish to bill for more than one physician may obtain a physician group billing number.

Scope of Service

The policies in Part S govern services provided within the scope of the practice of the profession as defined in s.49.46(2)(b)10, Wis. Stats. And HSS 101.03(75m) and 107.31, Wis. Admin. Code. Covered services and related limitations are enumerated in Section II of this handbook.

Reimbursement for Hospice Services

The hospice is reimbursed for the care of a recipient based on one of the following four types of care, and for nursing home room and board when appropriate.

- Routine home care, with a per diem rate for <u>less</u> than eight hours of care per day;
- Continuous home care, with an hourly rate for <u>at least</u> eight hours up to 24 hours of care per day;
- Inpatient respite care in a hospital or nursing facility (NF) meeting NF staffing, hourly and environmental requirements;
- General inpatient care in a hospital or NF;
- Nursing home “room and board”.

The rates to be paid for the four types of care or room and board are the per diem or hourly amounts allowed by the federal Health Care Financing Administration (HCFA). For hospice recipients who permanently reside in a nursing home, the amount for room and board for the nursing home is 95 percent of the nursing home’s current SNF and ICF I and II (blended daily rate), per the recipient’s level of care designation. Paid hospice claims for nursing home room and board are <u>not</u> adjusted if the nursing home’s rate is changed retroactively. Nor is patient liability deducted from the hospice claim.

In those cases where the recipient resides in a nursing home or is receiving inpatient respite care or general inpatient care in a hospital, the WMAP pays the per diem rate to the hospice. The hospice, in turn, is responsible for making the room and board payment to the nursing home or hospital.

B. PROVIDER INFORMATION (continued)

The hospice must reimburse any provider with whom it has contracted for service, including a facility providing inpatient care under HSS 107.31(3)(a), Wis. Admin. Code.

Reimbursement for Physician Services

The rates for the four types of hospice care and room and board are intended to include the general supervisory functions of attending physicians who are employed by, or under contract to, the hospice. Services such as participation in the establishment of plans of care, supervision of care and services, review or updating of plans of care or establishment of governing policies are not separately reimbursed since these costs are included in the hospice rates.

Payment for direct care by an attending physician employed by or under contract to the hospice is not included in the hospice cap amount. They are paid at the lesser of the billed amount or the maximum allowable fee established for each procedure.

Hospice Cap on Overall Reimbursement

A maximum amount shall be established by HCFA for aggregate payments made to a hospice during a hospice cap period which runs from November 1 through October 31 of the following year. Refer to Appendix 1 of this handbook for a definition of hospice cap period. The payments do not include payment for services made by other than the attending physician. Payments made to the hospice by the WMAP in excess of the cap on overall reimbursement will be recouped. The Bureau of Health Care Financing (BHCF) will notify the provider of the overpayment and the required repayment.

Payments are measured in terms of all payments made to hospices on behalf of all Medical Assistance hospice beneficiaries receiving services during the cap year, regardless of which year the beneficiary is counted in determining the cap. Inpatient days for persons with AIDS diagnoses are not included in the calculation of aggregate inpatient days and are not subject to the cap limitations.

The computation and application of the cap amount is made by the BHCF at the end of the cap period. The hospice will be responsible for reporting the number of Medical Assistance recipients electing hospice during the period to the BHCF. This must be done by November 30 of each year.

Provider Responsibilities

Specific responsibilities as a provider under the WMAP are stated in Section IV of Part A of the WMAP Provider Handbook. This section should be referenced for detailed information regarding fair treatment of the recipient, maintenance of records, recipient requests for noncovered services, services rendered to a recipient during periods of retroactive eligibility, grounds for provider sanctions, and additional state and federal requirements.

C. RECIPIENT INFORMATION

Eligibility For Medical Assistance

Recipients meeting eligibility criteria for Medical Assistance are issued Medical Assistance identification cards. The identification cards include the recipient's name, date of birth, 10-digit Medical Assistance identification number, medical status code, and when applicable, an indicator of private health insurance coverage, managed care program coverage, and Medicare coverage.

D. RECIPIENT INFORMATION (continued)

Medical Assistance identification cards are sent to recipients on a monthly basis. All Medical Assistance identification cards are valid only through the end of the month for which they are issued. It is important that the provider or the designated agent check a recipient's Medical Assistance identification card prior to providing service to determine if the recipient is currently eligible and if there are any limitations to the recipient's coverage.

Medical Assistance recipients (except those in WMAP-contracted managed care programs) who have elected hospice receive a red card which has the words “hospice” and “physician” printed on the card. The provider numbers shown on the card indicate the actual hospice or attending physician providing service to the recipient. This card must be used for all services related to the terminal illness, and the providers indicated are the only providers who may be reimbursed for these services. A sample hospice Medical Assistance identification card can be found in Appendix 4 of this handbook.

Section V-C of Part A of the WMAP Provider Handbook provides detailed information regarding eligibility for Medical Assistance, Medical Assistance identification cards, temporary cards, restricted cards, and how to verify eligibility. It must be reviewed carefully by the provider before services are rendered.

Medical Status

Medical Assistance recipients are classified into one of several eligibility categories. These categories allow for a differentiation of benefit coverage. Refer to Section V-E of Part A of the Provider Handbook for additional information regarding special benefit categories.

Recipients Eligible for Hospice Services

A Medical Assistance recipient is eligible for hospice services if the following conditions are met:

1. The recipient is certified by a physician as having a terminal illness which reduces life expectancy to six months or less if the terminal illness runs its normal course.

2. The recipient elects the hospice benefit and waives regular Medical Assistance benefits for care and/or treatment of the terminal illness or related condition. Refer to Section II-C of this handbook for information on physician certification of recipient terminal illness and recipient election of hospice benefits.

Recipients Enrolled in WMAP-Contracted Managed Care Programs

WMAP recipients enrolled in WMAP-contracted managed care programs receive a yellow Medical Assistance identification card and must receive hospice services through the managed care program. This card has a six-character code in the "Other Coverage" column designating the recipient's managed care program. The codes are defined in Appendices 20, 21, and 22 of Part A of the WMAP Provider Handbook.

Providers must always check the recipient’s current Medical Assistance identification card for managed care program coverage before providing services. Claims submitted to EDS for hospice services covered by WMAP-contracted managed care programs are denied.

E. RECIPIENT INFORMATION (continued)

To serve a recipient who is covered by a WMAP-contracted managed care program, the hospice provider must make arrangements with the WMAP-contracted managed care program, since the managed care program is responsible for authorizing and providing hospice services to recipients enrolled in WMAP-contracted managed care programs.

For recipients enrolled in a WMAP-contracted managed care program, all conditions of reimbursement and prior authorization for hospice services provided to a managed care program enrollee are established by the contract between the managed care programs and the certified hospice.

Copayment

Hospice services are exempt from recipient copayment. Services that are not directly related to management or palliation of the recipient's terminal illness are subject to copayment.

A. INTRODUCTION

Definition of Hospice

S. HSS 107.31, Wis. Adm. Code defines hospice services as "those services provided to an eligible recipient by a provider certified under s. HSS 105.50 which are necessary for the palliation and management of terminal illness and related conditions. These services include supportive care provided to the family and other individuals caring for the terminally ill recipient." Hospice services are an allowable benefit when provided to a Medical Assistance recipient in the recipient's home, a hospital, or a nursing facility (NF).

Hospice covered services consist of two categories, core services and other services. The hospice must maintain professional, financial, and administrative responsibility for both core and other services.

B. COVERED SERVICES

Core Services

Core services required under HSS 107.31(2)(c), Wis. Adm. Code must be provided directly by the hospice unless an emergency or extraordinary circumstances exists.

The following services are core services which must be provided directly by hospice employees unless the recipient is receiving Inpatient Respite or General Inpatient Care.

1. Nursing care by, or under the supervision of, a registered nurse (RN);
2. Administrative and supervisory physician services;
3. Medical social services provided by a social worker under the direction of a physician. The social worker must have a least a bachelor's degree in social work from a college or university accredited by the Council of Social Work Education;
4. Counseling services, including but not limited to bereavement counseling, dietary counseling, and spiritual counseling. Counseling services must be provided to the terminally ill and the family members or other persons caring for the individual at home. Note that bereavement counseling is not reimbursed by Medical Assistance.

Other Services

A hospice contract for other supplemental services required under HSS 107.31(2)(d), Wis. Adm. Code, in order to meet unusual staffing needs in cases where it is not practical to hire additional staff or to obtain physician specialty services. The contract must include identification of services to be provided, the qualifications of the contractor's personnel, the role and responsibility of each party, and a stipulation that all services provided be in accordance with applicable state and federal statutes, rules and regulations, and conform to accepted standards of professional practice. Other services include:

1. Physical therapy;
2. Occupational therapy;

B. COVERED SERVICES (continued)

3. Speech pathology;

NOTE: Therapy and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

4. Home health aide services furnished by qualified aides and homemaker services. Home health aides and personal care workers may provide personal care services and household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervisions of a registered nurse. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment, and services necessary to complete the plan of care.

5. Durable medical equipment, disposable medical supplies, and self-help or personal care items related to palliation or management of the patient's terminal illness, provided by the hospice for use in the patient's home while under hospice care, as part of the written plan of care;

6. Drugs which are used primarily for the relief of pain and symptom control and related to the individual's terminal illness;

7. Short-term inpatient care provided in a hospital, SNF, or ICF, for pain control, symptom management and respite purposes. This includes General Inpatient Care for pain control and management of acute symptoms and Inpatient Respite Care furnished to provide family and caregivers with respite.

C. CONDITIONS AND PROCEDURES FOR COVERAGE OF HOSPICE SERVICES

Physician Certification/Recertification of Terminal Illness Form

The recipient must have written certification by the hospice medical director, the physician member of the interdisciplinary team, or the recipient's attending physician that the recipient has a terminal illness which reduces life expectancy to six months or less, if the terminal illness runs its normal course. Refer to Appendix 5 of this handbook for a sample Physician Certification/Recertification of Terminal Illness form. Refer to Appendix 1 of this handbook for a definition of interdisciplinary team.

The hospice must obtain a written certification statement prepared by the medical director or physician member of the hospice's interdisciplinary team, that the individual's medical prognosis is a life expectancy of six months or less. The physician(s) must sign the statement and the hospice must keep a record of this in the recipient's file.

The hospice is allowed up to eight days to obtain a written physician certification of a patient's terminal illness if an oral certification is obtained within two days after the initial period of care begins. If the physician's written certification is not obtained in a timely manner, only services provided on or after the signature date of the physician's certification are reimbursed.

Notification of Medical Assistance Hospice Benefit Election Form

When a Medical Assistance recipient elects the WMAP hospice benefit, the hospice must notify EDS, and the Bureau of Quality Compliance (BQC) using the Notification of Medical Assistance Hospice Benefit Election Form, that the recipient has so elected and must do so within 30 calendar days of election of the hospice benefit.

C. CONDITIONS AND PROCEDURES FOR COVERAGE OF HOSPICE SERVICES (continued)

The name and performing provider number of the attending physician must be indicated on the election form. This will allow EDS to pay claims for the attending physician.

If the recipient electing hospice is or becomes a resident of a SNF or ICF, the hospice must submit a statement to EDS that the recipient resides in a nursing home and name the nursing home. Claims submitted for room and board payment will be denied if EDS has not received notice of the recipient's nursing home residence. The nursing home's WMAP provider number and the recipient's Medical Assistance identification number must be indicated. Refer to Appendix 6 of this handbook for the Notification of Medical Assistance Hospice Election form which must be used by all Hospice providers.

Recipient Election of Medical Assistance Hospice Benefit Form
A Recipient Election of Medical Assistance Hospice Benefit form must be filed with the hospice for the Medical Assistance recipient who has been certified as terminally ill and who elects to receive hospice care. The election date must designate the first date of service for which hospice care will be provided. A recipient who files an election statement waives regular WMAP benefits for care or treatment of the terminal illness and related conditions, except the services provided by an attending physician are not waived. Refer to Appendix 1 of this handbook for a definition of attending physician. The recipient may discontinue the election of hospice care at any time and thereby have all WMAP benefits reinstated. A recipient may choose to reinstate hospice care services subsequent to discontinuation. In the event of reinstatement, the requirements of this section again apply.

The hospice must obtain the written consent of the recipient, or recipient's representative, for hospice care on the recipient election statement form. This must be signed by the recipient, or the recipient's representative, and indicate that the recipient is informed about the type of care and services that may be provided to the recipient by the hospice during the course of illness, and the effect of the recipient's waiver of regular WMAP benefits. Refer to Appendix 7 of this handbook for a sample Recipient Election of Medical Assistance Hospice Benefit form.

Forms Requirements
Hospice providers may use the physician certification and recipient election statement forms developed by the WMAP, forms used by Medicare, or forms developed by the hospice. Refer to Appendices 5 and 7 for sample forms. Hospice providers are, however, required to use the Notification of Medical Assistance Hospice Benefit Election Form developed by the WMAP. Refer to Appendix 6 for a sample of the required hospice benefit election form.

While providers are not required to use the physician certification and recipient election statement forms provided by the WMAP, any physician certification or recipient election statement used by a hospice must include the following information:

1. Physician Certification/Recertification of Terminal Illness form:

   a. the name and Medical Assistance identification number of the recipient;
   b. the physician's statement certifying terminal illness; within six months
   c. the name and Medical Assistance provider number of the attending physician;
   d. the certification date of the hospice election.

2. Recipient Election of Medical Assistance Hospice Benefit form:

   a. the name and provider number of the hospice;
   b. the name and Medical Assistance identification number of the recipient;
   c. the name of the hospice;
   d. the signature of the recipient or legal representative and the date of signature;
   e. the signature of a witness and the date of signature;
   f. signed acknowledgement that the recipient understands the following principles of the hospice benefit:

      - the hospice program is palliative, not curative;
      - only the elected hospice and attending physician are eligible to receive payment for services related to the terminal illness;
      - hospice care may be discontinued at any time;
      - hospice care may be re-elected at any time after being discontinued;
      - hospice care may be received from another hospice at any time during the benefit period, without loss of hospice benefit days, by electing a new hospice.

Copies of all WMAP hospice forms may be obtained by writing to the following address:

EDS
Attn: Claim Reorder
6406 Bridge Road
Madison, WI 53784-0003

Form Submission and Retention
Hospice enrollment records must be kept with the recipient's records in accordance with s.HSS 106.02(9), Wis. Adm. Code.

Upon enrollment or a change of enrollment, the Physician Certification/Recertification of Terminal Illness Form (or its equivalent), the Notification of Medical Assistance Hospice Benefit Election Form (or its equivalent) must be sent to EDS as the following addresses within 30 calendar days of election:

EDS
Attn: Recipient Services
6406 Bridge Road
Madison, WI 53784-7636

Upon election of hospice, the recipient is "locked-in" to this benefit. The effective date of the hospice lock-in is the first "from" date on the next Medical Assistance identification card issued after receipt of the election form.

When EDS receives the Physician Certification/Recertification of Terminal Illness Form, the notification of Medical Assistance Hospice Benefit Form, and Recipient Election of Medical Assistance Hospice Benefit Form, the recipient will be locked into receiving all services from the hospice and attending physician indicated, regardless of whether or not that physician is employed by the hospice.

Hospice are not required to submit these forms for recipients who are enrolled in WMAP-contracted HMOs. The hospice must contact the recipient's HMO for instructions on specific information required by the HMO.

Plan of Care
A written plan of care must be established for recipients who elect to receive hospice services before hospice care is provided. This plan must be established by the attending physician, the medical director or physician designee, and the interdisciplinary team.

Hospice Discontinuation or Transfer by Recipient
A recipient may discontinue the election of hospice care at any time. Upon discontinuation of the election of hospice for a particular election period, the recipient resumes regular WMAP coverage for the benefits waived when hospice care was elected, so long as the recipient remains eligible for Medical Assistance. Upon discontinuation of the hospice election, the recipient receives a standard Medical Assistance identification card. An individual may at any time elect to receive hospice coverage for any other hospice election periods for which he or she is eligible.

An individual may change, once in each election period, the designation of the particular hospice from which he or she elects to receive hospice care. The change of the designated hospice is not considered a discontinuation of the election.

To change the designation of hospice programs, the individual must file with the hospice from which he has received care and with the newly designated hospice, a signed statement that includes the following:

- name of the hospice from which the patient has received care;
- name of the hospice from which he plans to receive care; and
- the date the change will be effective.

If a hospice recipient chooses to discontinue or transfer hospice services, the hospice must notify EDS within five working days of the date of discontinuation or transfer at the following address:

EDS
Attn: Recipient Services
6406 Bridge Road
Madison, WI 53784-7636

Admission to a Nursing Facility
If the hospice recipient is or becomes a nursing home resident for other than inpatient respite care, a copy of the Notification of Medical Assistance Hospice Benefit Election Form must be sent to the following address:

Bureau of Quality Compliance
Attn: Chief, Facilities Regulations Section
Post Office Box 309
Madison, WI 53701-0309

Note: All information regarding nursing home admission must be sent to both EDS and BQC.

D. HOSPICE CARE SERVICES AND RELATED LIMITATIONS

Hospice services covered by WMAP are billed under 5 categories of service indicated below. Refer to Section IV of this handbook of billing information, and Appendix 8 of this handbook for a listing of billable revenue codes, their descriptions, and the appropriate billing increments.

1. Continuous Home Care

Continuous home care is provided when a patient requires continuous care, which is primarily nursing care for palliation and management of acute medical symptoms.

The WMAP will reimburse a hospice for continuous home care if a minimum of eight hours up to a maximum of 24 hours of care is provided on a date of service. A date of service begins and ends at midnight. The recipient may be at home or permanently residing in a nursing facility.

Continuous home care is a period of nursing care which must be provided by either a RN or licensed practical nurse (LPN). A RN or LPN must be providing care for more than half the minimum eight hour period in a 24-hour period. For any date of service, a hospice must not bill the WMAP for more than time the amount of time the RN or LPN provides care to the recipient. The time billed does not need to be continuous (e.g., four hours in the morning and four hours in the afternoon). Homemaker and aide services may be provided to supplement the nursing care.

Limitations Applicable to Continuous Home Care
Continuous home care is not reimbursed on the same date of service as routine home care, general inpatient care, or inpatient respite care for the same recipient.

2. Routine Home Care

Routine Home Care is less skilled care needed on a regular, part-time basis and is provided in the recipient's place of residence (i.e., home or nursing facility).

Each day the recipient is at home, and/or permanently residing in a nursing facility, receiving care from the hospice, and not receiving continuous home care, inpatient respite care or general inpatient care, is defined as routine home care. The WMAP will only reimburse a hospice for routine home care if less than eight hours of care are provided in a day.

Limitations Applicable to Continuous Home Care

Routine home care is not reimbursed for the same date of service as continuous home care, inpatient respite care, or general inpatient care for the same recipient.

3. Inpatient Respite Care

Inpatient respite care is short-term inpatient care provided to the hospice recipient only when necessary to relieve the family members or other persons caring for the recipient at home.

Limitations Applicable to Inpatient Respite Care

Inpatient care for respite purposes must be provided by a WMAP-certified hospital, a skilled nursing facility (SNF), or an intermediate care facility (ICF) which meets additional certification requirements noted in 42 CFR 405.1101 - .1137 and in Ch. HSS 132 to meet SNF standards regarding staffing, patient areas, and 24 hour nursing service for skilled nursing facilities. Respite care is the only type of inpatient care allowed in an ICF.

An inpatient stay for respite care must not exceed five consecutive days at a time including the date of admission but not counting the date of discharge. Each day that inpatient care is provided must be billed using the inpatient respite care revenue code. Respite care must not be provided when the hospice recipient is already residing in a nursing home.

A hospice may not be reimbursed for respite care for individuals whose permanent place of residence is in a nursing facility.

Inpatient care exceeding five consecutive days must be medically necessary for pain control and symptom management and must be billed as general inpatient care.

Inpatient respite care is not reimbursed for the same date of service as general inpatient care, continuous home care, routine home care, or room and board for the same recipient.

4. General Inpatient Care

General inpatient care is short-term inpatient care necessary for pain control and symptom management.

Each day general inpatient care is provided must be billed using the general inpatient care revenue code. Any WMAP-certified hospital or SNF is considered to be an inpatient setting for the purposes of general inpatient care.

Limitations Applicable to Inpatient Respite Care and General Inpatient Care

General inpatient care must be provided by a WMAP-certified hospital or skilled nursing facility certified by the WMAP or by a hospice certified under 42 CFR 418 meeting conditions specified under 42 CFR 418.98.

For each hospice, the total number of inpatient days (both for general inpatient care and inpatient respite care) must not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medical Assistance recipients enrolled in the hospice during the same period beginning with services rendered November 1 of each year and ending October 31 of the next year. This limitation is applied once each year, at the end of the hospice cap period. Inpatient days for persons with AIDS diagnoses are not included in these limitations.

If the aggregate number of inpatient days does exceed 20 percent of the aggregate total number of days of hospice care, the provider is required to reimburse the WMAP for the amount of reimbursement for days over the 20 percent cap. The WMAP will notify the provider of the overpayment and the required reimbursement.

For the date of discharge from an inpatient unit, the appropriate home care procedure code must be billed rather than an inpatient code, unless the recipient dies as an inpatient. When the patient is discharged deceased, the general or respite inpatient care procedure code must be billed for the discharge date.

General inpatient care is not reimbursed for the same date of service as room and board in a SNF or ICF, inpatient respite care, continuous home care or routine home care, for the same recipient.

5. Room and Board for a SNF or ICF Resident

When a resident of a WMAP-certified SNF or ICF elects to receive hospice care services, the hospice must contract with that facility to provide the recipient's room and board and the hospice assumes responsibility for the professional management of the individual's hospice care. Room and board includes assistance in activities of daily living and personal care, socializing activities, administration of medications, maintaining cleanliness of the recipient's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies. In this situation, the WMAP will reimburse the hospice for room and board charges and the hospice will pay the nursing facility.

Each day that room and board in an SNF/ICF is provided must be billed using the room and board revenue code. Continuous or routine home care may be billed as appropriate.

Limitations Applicable to Room and Board for a SNF or ICF Resident

Room and board for a SNF or ICF resident is not reimbursed for the same date of service as inpatient respite care or general inpatient care.

E. PHYSICIAN SERVICES

Covered physician services are those direct care services related to the recipient's terminal illness. Refer to Appendix 9 of this handbook for an all inclusive list of HCPCS procedure code ranges for physician services which may be separately billed by the hospice or the attending physician for a hospice recipient. Claims submitted for a hospice recipient which indicate procedure codes other than those listed are denied. Noncovered physician services within these code ranges are also not covered for hospice recipients.

Services provided by a physician other than the attending physician are only payable when deemed medically necessary by the attending physician. Claims for these services are subject to consultant review for medical necessary prior to payment.

F. NONCOVERED SERVICES

The following services/items are not covered benefits of the WMAP for hospice recipients:

- services which are curative, rather than palliative;
- administrative and supervisory physician services which are included in the hospice daily rate;
- physician services which are not covered for all Medical Assistance recipients.
- services related to the terminal illness which are provided by providers other than the hospice, its contractees, or the attending physician. Refer to Appendix 11 for a list of noncovered services.

A. SERVICES REQUIRING PRIOR AUTHORIZATION

Hospice services do not require prior authorization. Allowable services which would otherwise require prior authorization do not require prior authorization when billed by the attending physician for a hospice recipient.

A. COORDINATION OF BENEFITS

The Wisconsin Medical Assistance Program (WMAP) is the payer of last resort for any service covered by the WMAP. If the recipient is covered under other insurance (including Medicare), the WMAP reimburses that portion of the allowable cost remaining after all other insurance sources have been exhausted. Refer to Section IX-D of Part A of the WMAP Provider Handbook for more detailed information on services requiring third party billing, exceptions, and the "Other Coverage Discrepancy Report."

B. MEDICARE/ MEDICAL ASSISTANCE DUAL ENTITLEMENT

Recipients covered under both Medicare and Medical Assistance are referred to as dual-entitlees. Since hospice is a Medicare covered benefit, all claims submitted for payment for dual entitlees or QMBs must be submitted to Medicare prior to billing the WMAP. However, claims for “room and board” only do not need to be submitted to Medicare, since Medicare does not cover this service.

Refer to Section IX-C of Part A of the WMAP Provider Handbook for more information about Medicare/Medical Assistance dual entitlement and QMB-only status.

A Medicare disclaimer code must be indicated on the claim if the recipient has Medicare as indicated in the claim form instructions in Appendix 2 of this handbook.

Automatic crossover claims will be processed if “T19-WI Medicaid” is indicated in Item 50 (Payer Identification) and the recipient’s Medical Assistance identification number is indicated in Item 60 (Certificate Number, Social Security Number, Health Insurance Claim Number, Identification Number) on the UB-92 claim form. Refer to Appendix 2 of this handbook for UB-92 claim form completion instructions.

C. BILLED AMOUNTS

Hospice providers billing for continuous home care, routine home care, inpatient respite care or general inpatient care must bill the WMAP their usual and customary charge for services provided, that charge being the amount charged by the provider for the same service when provided to private-pay patients. For providers using a sliding fee scale for specific services, usual and customary means the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Providers may not discriminate against Medical Assistance recipients by charging a higher fee for the service than is charged to a private pay patient.

Hospice providers billing for room and board must bill the nursing home room and board rate established for that nursing home by the WMAP, which is in effect for the dates of service (i.e., 95% of the nursing home’s Medical Assistance daily rate).

Physician services billed by the hospice or attending physician should be billed at the usual and customary rate.

Providers should refer to Appendix 2 of this handbook for complete billing instructions.

D. BILLING INCREMENTS

Hospice providers must bill in hour or half-hour increments, rounded to the nearest half-hour, for continuous home care services. Providers should refer to Appendix 10 of this handbook for rounding guidelines to be used for calculating the number of hours of service to be billed.

Routine home care, general inpatient care, inpatient respite care, and room and board must be billed as a quantity of “1” per date of service.

E. CLAIM SUBMISSION

Paper Claim Submission

1. Hospice Care Services

   Hospice services other than physician services must be submitted on the UB-92 claim form. Hospice services submitted on any form other than the UB-92 claim form are denied. When Medicare is the primary payer, the Medicare instructions must be followed. All other UB-92 claim forms submitted must follow the UB-92 claim form instructions developed by the WMAP. A sample claim form and completion instructions can be found in Appendices 2 and 3 of this handbook.

2. Attending Physician Services

   Physician services provided by an attending physician must be billed on the National HCFA 1500 claim form using WMAP allowable Type of Service (TOS) and HCFA Common Procedure Coding System (HCPCS) codes.

   All claims submitted for attending physician services must indicate type of service "H" in element 24C of the HCFA 1500 claim form in order for the claim to be exempt from any applicable prior authorization and recipient copayment requirements.

   The billing provider in element 33 of the HCFA 1500 claim form may be the hospice, the attending physician, or a clinic or billing group with whom the attending physician is affiliated. If a hospice, clinic, or billing group number is indicated in element 33 as the billing provider, the attending physician's eight-digit WMAP provider number must be indicated as the performing provider in element 24K.

3. Other Physician Services

   Services related to the terminal illness which are rendered by physicians other than the primary attending physician are only payable when deemed medically necessary by the attending physician. These claims are reviewed for appropriateness of the service by the WMAP medical consultant before payment is approved. These services must be billed using type of service "H" and the "unlisted" procedure code from the appropriate section of CPT-4 (e.g., "suture of facial nerve, extracranial" would be billed using the "unlisted" procedure code for the nervous system, 64999, and TOS H).

   In addition, claims for physician services rendered by other than the attending physician must indicate the name and WMAP provider number of the attending physician in the referring physician portion of the HCFA 1500 claim form (Elements 17 and 17a).

Ordering Claim Forms

The UB-92 and HCFA 1500 claim forms are not provided by the WMAP or EDS. They may obtained from a number of forms suppliers. One such source for UB-92 claim forms is:

Standard Register
Post Office Box 6248
Madison, WI 53716
(608) 222-4131

E. CLAIM SUBMISSION (continued)

HCFA 1500 claim forms may be obtained from:

State Medical Society Services
Post Office Box 1109
Madison, WI 53701
(608) 257-6781 (Madison area)
1-800-362-9080 (toll-free)

Completed claims submitted for payment must be mailed to the following address:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Service limitations and billing instructions for physician services are included in the physician handbook, Part K. Hospice providers who do not have the handbook may purchase copies by writing to EDS. Refer to Appendix 3 of Part A of the WMAP Provider Handbook for the correct address.

Paperless Claim Submission
As an alternative to submission of paper claims, EDS is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted through these systems have the same legal requirements as claims submitted on paper and will be subjected to the same processing requirements as those submitted on paper. Software for electronic submissions may be obtained free of charge. Electronic submissions have substantial advantages in reducing clerical effort and errors, reducing mailing costs and delays, and improving processing time. Additional information on alternative claim submission is available by contacting:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

Submission of Claims
All claims for services rendered to eligible WMAP recipients must be received by EDS within 365 days from the date the service was rendered. This policy pertains to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals can be found in Section IX-F of Part A of the WMAP Provider Handbook.

F. DIAGNOSIS CODES

All diagnosis must be from the ICD-9-CM (International Classification of Diseases, 9th Edition, Clinical Modifications) coding structure.

Claims received without the appropriate ICD-9-CM code are denied.

The complete ICD-9-CM code book can be ordered from:

ICD-9-CM
Post Office Box 991
Ann Arbor, MI 48106

F. DIAGNOSIS CODES (continued)

Providers should note the following diagnosis code restrictions:

- Codes with an "E" prefix must not be used as the primary or sole diagnosis on a claim submitted to the WMAP.
- Codes with an "M" prefix are not acceptable on a claim submitted to the WMAP.
- Recipients with a diagnosis of AIDS/ARC must be identified with ICD-9-CM codes 042-0439 for their services to be exempt from the hospice cap.

G. PROCEDURE CODES

All claims submitted to the WMAP must include both service descriptions and revenue or procedure codes. Revenue codes are required on all UB-82 claims, and HCPCS codes are required on all HCFA 1500 claims. Claims or adjustments received without revenue or HCPCS codes are denied. Allowable revenue codes and their descriptions for hospice services are included in Appendix 8 of this handbook. Allowable HCPCS code ranges for physician services provided to hospice recipients are included in Appendix 9 of this handbook. Refer to CPT-4 manual for a complete list of codes and their descriptions.

H. FOLLOW-UP TO CLAIM SUBMISSION

It is the responsibility of the provider to initiate follow-up procedures on claims submitted to EDS. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Providers are advised that EDS will take no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to EDS. Section X of Part A of the WMAP Provider Handbook includes detailed information regarding:

- the Remittance and Status Report
- adjustments to paid claim
- return of overpayments
- duplicate payments
- denied claims
- Good Faith claims filing procedures

HOSPICE
APPENDICES

APPENDIX 1

DEFINITIONS OF COMMON TERMS

1. **Attending physician:** A physician who is a doctor of medicine or osteopathy certified under sec. HSS 105.05, Wis. Adm. Code and identified by the recipient as having the most significant role in the determination and delivery of his or her medical care at the time the recipient elects to receive hospice care.

2. **Core services:** Those services listed in HSS 107.31(2). Wis. Adm. Code, which must be provided directly by the hospice unless an emergency or extraordinary circumstance requires the hospice to contract for services.

3. **Hospice cap period:** The period of time during which the payment for those hospice services counting towards the cap will be counted, by date of service. The cap period runs from November 1 to October 31 of the following year.

4. **Interdisciplinary team or group:** A group of persons designated by a hospice to provide or supervise care and services made up of at least a physician, a registered nurse, a medical social worker and a pastoral counselor or other counselor, all of whom are employees of the hospice.

5. **Physician designee:** A person designated by the physician to participate in establishing the written plan of care.

APPENDIX 2
INSTRUCTIONS FOR COMPLETION OF THE
NATIONAL UB-92 CLAIM FORM FOR HOSPICE SERVICES

These instructions must be used in conjunction with the UB-92 Billing Manual prepared by the State Unified Billing Committee (SUBC). The UB-92 Billing Manual contains important coding information not available in these instructions. A copy of the UB-92 Billing Manual may be obtained from the Wisconsin Hospital Association.

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "optional" or "not required" is specified.

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

ITEM 1 – PROVIDER NAME, ADDRESS & TELEPHONE NUMBER
Enter the name, address, city, state, and zip code of the billing provider.

ITEM 2 – UNLABELED FIELD (not required)

ITEM 3 – PATIENT CONTROL NUMBER (optional)
Provider may enter the patient's internal office account number. This number will appear on the EDS Remittance and Status Report (maximum of 17 characters for paper, electronic, or tape claims).

ITEM 4 – TYPE OF BILL
Enter a three-digit code indicating the specific type of bill. The first digit identifies the type of facility. The second digit classifies the type of care. Non-hospital based hospice providers are to use bill type 81X; hospital-based hospices providers are to use 82X. The third digit ("X") indicates the billing frequency, and should be assigned as follows:

1 = Inpatient admit through discharge claim
2 = Interim bill – first claim
3 = Interim bill – continuing claim
4 = Interim bill – final claim

ITEM 5 – FEDERAL TAX NUMBER (not required)

ITEM 6 – STATEMENT COVERS PERIOD (not required)

ITEM 7 – COVERED DAYS (not required)

ITEM 8 – NONCOVERED DAYS (not required)

ITEM 9 – COINSURANCE DAYS (not required)

ITEM 10 – LIFETIME RESERVE DAYS (not required)

ITEM 11 – UNIQUE PATIENT IDENTIFIED (not required)

ITEM 12 – PATIENT NAME
Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

ITEM 13 – PATIENT'S ADDRESS (not required)

ITEM 14 – PATIENT'S DATE OF BIRTH (not required)

ITEM 15 – PATIENT'S SEX (not required)

ITEM 16 – MARITAL STATUS (not required)

ITEM 17 – DATE OF ADMISSION (not required)

ITEM 18 – HOUR OF ADMISSION (not required)

ITEM 19 – TYPE OF ADMISSION (not required)

ITEM 20 – SOURCE OF ADMISSION (not required)

ITEM 21 – DISCHARGE HOUR (not required)

ITEM 22 – PATIENT STATUS (not required)

ITEM 23 – MEDICAL/HEALTH RECORD NUMBER (optional)
This number will not appear on the Remittance and Status Report.

ITEM 24-30 – CONDITION CODES (Optional)
If appropriate, enter a code to identify conditions relating to this claim that may affect payer processing.

Code	Explanation of Code
01	*Military service related:* Medical condition incurred during military service.
02	*Condition is employment related:* Patient alleges that medical condition is due to environment/events resulting from employment.
03	*Patient covered by insurance not reflected here:* Indicates that the patient or a representative has stated that coverage may exist beyond that reflected on this bill.
05	*Lien has been filed:* Provider has filed legal claim for recovery of funds potentially due a patient as a result of legal action initiated by or on behalf of the patient.
08	*Beneficiary would not provide information concerning other insurance coverage:* Enter this code if the beneficiary would not provide information concerning other insurance coverage.

See UB-92 Billing Manual for additional codes.

ITEM 31 – UNLABELED FIELD (not required)

ITEM 32-35(a-b) – OCCURRENCE CODES AND DATES
If appropriate, enter the code and associated date defining a significant event relating to this claim that may affect payer processing. All dates should be printed in the "MMDDYY" format.

Code	Explanation of Code
01	*Auto Accident:* Code indicating the date of an auto accident.
02	*Auto Accident/No Fault Insurance:* Code indicating the date of an auto accident where the state has applicable no fault liability laws.
03	*Accident/Tort Liability:* Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no fault liability.
04	*Accident/Employment Related:* Code indicating the date of an accident relating to the patient's employment.
05	*Other Accident:* Code indicating the date of an accident not described by the above codes.
06	*Crime Victim:* Code indicating the date on which a medical condition resulted from allegedly criminal action committed by one or more parties.
24	*Date Insurance Denied:* Code indicating the date the denial of coverage was received by the hospice from any insurer.
25	*Date Benefits Terminated by Primary Payer:* Code indicating the date on which coverage (including Worker's Compensation benefits or no-fault coverage) is no longer available to the patient.
42	*Date of Discharge:* For final bill of hospice care, enter the date the beneficiary terminated the election of hospice care.

See UB-92 Billing Manual for additional codes.

ITEM 36(a-b) – OCCURRENCE SPAN CODE AND DATES (not required)

ITEM 37 – INTERNAL CONTROL NUMBER (ICN)/DOCUMENT CONTROL NUMBER (DCN) (not required)

ITEM 38 – RESPONSIBLE PARTY NAME AND ADDRESS (not required)

ITEM 39-41(a-d) – VALUE CODES AND AMOUNTS
If appropriate, enter a value code and the related dollar amount necessary for processing this claim. The value code structure is intended to provide additional reporting capabilities.

Code	Explanation of Code
22	*Surplus:* Spenddown required to be entered if patient spenddown occurs. This code should be entered together with the dollar amount.
81	*Medicare Part B charges when Part A exhausted:* Enter the full amount of Medicare Part B charges when billing for services after Medicare Part A has been exhausted.

83 *Medicare Part A charges when Part A exhausted:* Enter the sum of the Medicare paid amount, the coinsurance amount, and the deductible amount when billing for services after Medicare Part A has been exhausted.

See UB-92 billing manual for additional codes.

ITEM 42 – REVENUE CODE
Enter the appropriate revenue code. Enter revenue code 001 on the last line, indicating the line on which the sum of all charges on the claim is placed.

REVENUE CODE TABLE FOR UB-92 HOSPICE CLAIMS

Code	Description
169	Room and Board for SNF/ICF resident
651	Routine Home Care (up to 7.5 hours)
652	Continuous Home Care (8-24 hours)
655	Inpatient Respite Care
656	General Inpatient Care
001	Total charges

NOTE: All other revenue codes will be denied.

ITEM 43 – REVENUE DESCRIPTION
Enter the date of service in MMDDYY format either in this item or in Item 45.

When series billing (i.e., billing from two to four dates of service on the same line), indicate the dates of service in the following format: MMDDYY MMDD MMDD MMDD. Indicate the dates in ascending order.

Providers may enter up to four dates of service for each revenue code if:

- All dates of service are in the same calendar month.
- All procedures performed are identical.
- All procedures were performed by the same provider.

If it is necessary to indicate more than four dates of service per revenue code, indicate the dates on subsequent lines. On paper claims, no more than 23 lines may be submitted on a single claim, including the "total charges" line.

ITEM 44 – HCPCS/RATES (not required)

ITEM 45 – SERVICE DATE
Enter the date of service in MMDDYY format either in this item or in Item 43. (Multiple dates of service must be indicated in Item 43.)

ITEM 46 – UNITS OF SERVICE
Enter the total number of days or hours billed on each line item. Units are measured in days for revenue codes 169, 651, 655 and 656, and in hours for revenue code 652.

ITEM 47 – TOTAL CHARGES (BY REVENUE CODE CATEGORY)
Enter the total charge for each line item. For revenue code 001 (total charges), enter the grand total for all services submitted on the claim.

ITEM 48 – NONCOVERED CHARGES (not required)

ITEM 49 – UNLABELED FIELD (not required)

ITEM 50 – PAYER IDENTIFICATION
Indicate the WMAP ("T19 – WI Medicaid") and all third-party payers (including Medicare) with possible involvement in this claim. All coverages indicated on the recipient's Medical Assistance identification care must be addressed.

ITEM 51 – PROVIDER NUMBER
Enter the provider's eight-digit provider number on the "T19 – WI Medicaid" line.

ITEM 52 – RELEASE INFORMATION CERTIFICATION INDICATOR (not required)

ITEM 53 – BENEFITS ASSIGNED (not required)

ITEM 54 – PRIOR PAYMENTS-PAYER AND PATIENTS
If applicable, enter the amount the provider has received toward payment of this bill prior to the billing date by the indicated payer. If "other insurance" denied the claim, enter $0.00. (Do not indicate Medicare payments.)

File an "Other Coverage Discrepancy Report" (Appendix 19 of Part A of the WMAP Provider Handbook) if coverage listed on the recipient's Medical Assistance identification card disagrees with the recipient's statement.

ITEM 55 – ESTIMATED AMOUNT DUE (not required)

ITEM 56 – UNLABELED FIELD (not required)

ITEM 57 – UNLABELED FIELD (not required)

ITEM 58 – INSURED'S NAME (not required)

ITEM 59 – PATIENT'S RELATIONSHIP TO INSURED (not required)

ITEM 60 – CERTIFICATE NUMBER, SOCIAL SECURITY NUMBER, HEALTH INSURANCE CLAIM NUMBER IDENTIFICATION NUMBER
On the "T19 – WI Medicaid" line, enter the recipient's 10-digit Medical Assistance identification number as found on the current Medical Assistance identification card.

ITEM 61 – INSURED GROUP NAME (not required)

ITEM 62 – INSURANCE GROUP NUMBER (not required)

ITEM 63 – TREATMENT AUTHORIZATION CODE (not required)

ITEM 64 – EMPLOYMENT STATUS CODE (not required)

ITEM 65 – EMPLOYER NAME (not required)

ITEM 66 – EMPLOYER LOCATION (not required)

ITEM 67 – PRINCIPAL DIAGNOSIS CODE
The International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. Manifestation ("M") codes are not valid diagnosis codes for Medical Assistance.

ITEM 68-75 – OTHER DIAGNOSIS CODES
Enter the full ICD-9-CM diagnosis codes corresponding to additional conditions related to treatment billed on the claim. Other diagnosis codes will permit the use of ICD-9-CM "E" codes. Manifestation ("M") codes are not valid diagnosis codes for Medical Assistance.

ITEM 76 – ADMITTING DIAGNOSIS (not required)

ITEM 77 – EXTERNAL CAUSE OF INJURY (E-CODE) (not required)

ITEM 78 – RACE/ETHNICITY (not required)

ITEM 79 – PROCEDURE CODING METHOD USED (not required)

ITEM 80 – PRINCIPAL PROCEDURE CODE AND DATE (not required)

ITEM 81(a-e) – OTHER PROCEDURE CODES AND DATES (not required)

ITEM 82(a-b) – ATTENDING PHYSICIAN ID
Enter the attending physician's name and UPIN number or eight-digit Medical Assistance provider number.

ITEM 83(a-b) – OTHER PHYSICIAN ID (not required)

ITEM 84 – REMARKS
Third-party insurance (commercial insurance coverage) must be billed prior to billing the WMAP, unless the service does not require third-party billing according to Appendix 18a of Part A of the WMAP Provider Handbook.

- When the provider has not billed other insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, the service does not require third party billing according to Appendix 18a of the WMAP Provider Handbook, or the recipient's Medical Assistance identification card indicates "DEN" only, this item must be left blank.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook, one of the following codes MUST be indicated. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID in part by other insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by private insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to the private insurer.

OI-Y YES, card indicates other coverage but it was not billed for reasons including, but not limited to:

- Recipient denies coverage or will not cooperate;
- The provider knows the service in question is noncovered by the carrier;
- Insurance failed to respond to initial and follow-up claim; or
- Benefits not assignable or cannot get an assignment.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	**Description**
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by the WMAP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill the WMAP for services which are included in the capitation payment.

Medicare must be billed prior to billing the WMAP. When the recipient's Medical Assistance identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes MUST be indicated. The description is required.

Code	**Description**
M-1	Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes, and home health agencies when Medicare has made payment up to the lifetime of its coverage.
M-5	Provider not Medicare certified for benefits provided.
M-6	Recipient not Medicare eligible.
M-7	Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.
M-8	Medicare was not billed because Medicare never covers this service.

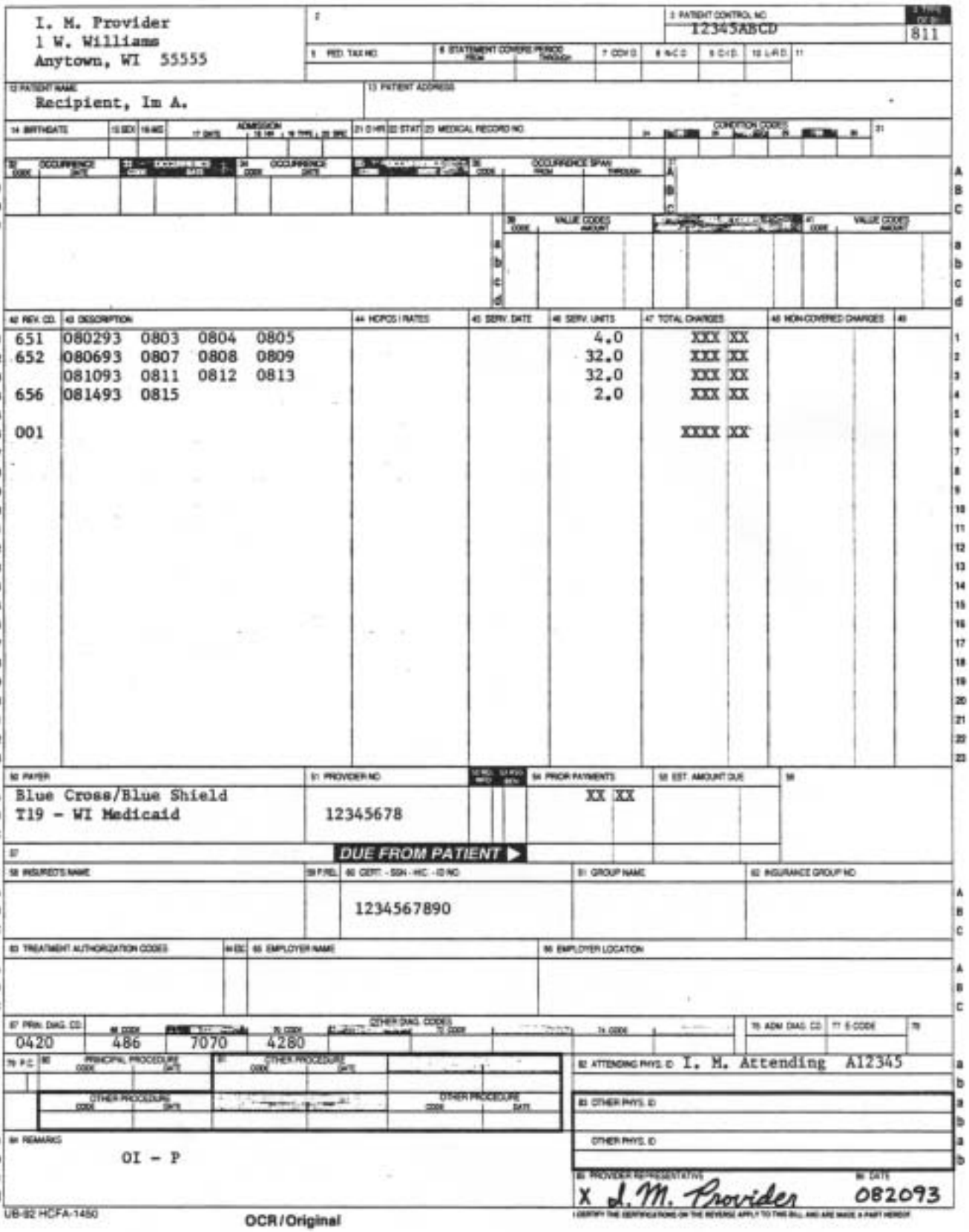
If Medicare is not billed because the recipient's Medical Assistance identification card indicated no Medicare coverage, this item must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Benefits (EOMB) must be attached to the claim and this item must be left blank. Refer to Appendix 17 of Part A of the WMAP Provider Handbook for further information regarding the submission of claims for dual entitlees.

ITEM 85 – PROVIDER REPRESENTATIVE SIGNATURE
The provider or the authorized representative must sign in item 85. This may be a computer printed name or a signature stamp.

ITEM 86 – DATE BILL SUBMITTED
Enter the date on which the bill is submitted to Medical Assistance in MMDDYY format.

APPENDIX 3
NATIONAL UB-92 CLAIM FORM SAMPLE



I. M. Provider
1 W. Williams
Anytown, WI 55555

1 PATIENT CONTROL NO: 12345ABCD
811

12 PATIENT NAME: Recipient, Im A.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
651	080293 0803 0804 0805			4.0	XXX XX		
652	080693 0807 0808 0809			32.0	XXX XX		
	081093 0811 0812 0813			32.0	XXX XX		
656	081493 0815			2.0	XXX XX		
001					XXXX XX		

50 PAYER: Blue Cross/Blue Shield
T19 - WI Medicaid

51 PROVIDER NO: 12345678

54 PRIOR PAYMENTS: XX XX

DUE FROM PATIENT

60 INSURED'S I.D. - SSN - HIC - ID NO: 1234567890

67 PRIN. DIAG. CD: 0420
OTHER DIAG. CODES: 486 7070 4280

82 ATTENDING PHYS. ID: I. M. Attending A12345

84 REMARKS: OI - P

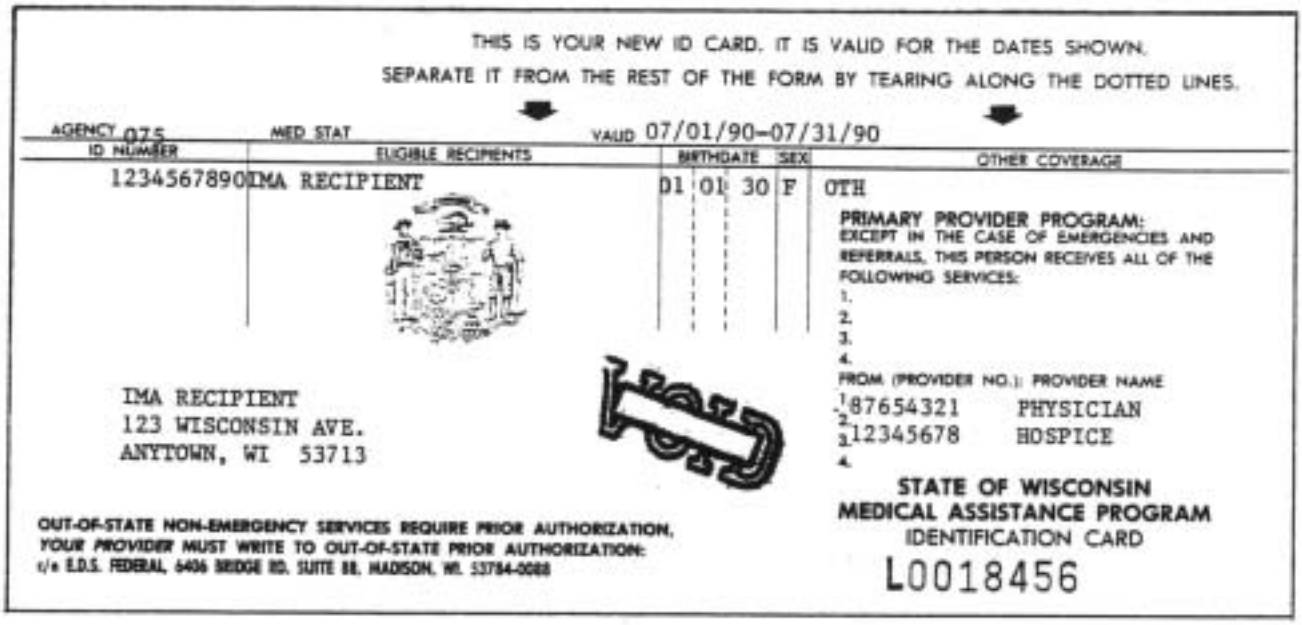
PROVIDER REPRESENTATIVE: X J. M. Provider
DATE: 082093

UB-92 HCFA-1450

OCR / Original

APPENDIX 4

MEDICAL ASSISTANCE (MA) IDENTIFICATION (ID) CARD SAMPLE FOR A HOSPICE RECIPIENT



THIS IS YOUR NEW ID CARD. IT IS VALID FOR THE DATES SHOWN.
SEPARATE IT FROM THE REST OF THE FORM BY TEARING ALONG THE DOTTED LINES.

AGENCY 075 MED STAT VALID 07/01/90–07/31/90

ID NUMBER	ELIGIBLE RECIPIENTS	BIRTHDATE	SEX	OTHER COVERAGE
1234567890	IMA RECIPIENT	01 01 30	F	OTH

IMA RECIPIENT
123 WISCONSIN AVE.
ANYTOWN, WI 53713

PRIMARY PROVIDER PROGRAM:
EXCEPT IN THE CASE OF EMERGENCIES AND REFERRALS, THIS PERSON RECEIVES ALL OF THE FOLLOWING SERVICES:
1.
2.
3.
4.

FROM (PROVIDER NO.): PROVIDER NAME
1 87654321 PHYSICIAN
2 12345678 HOSPICE
3
4.

OUT-OF-STATE NON-EMERGENCY SERVICES REQUIRE PRIOR AUTHORIZATION. YOUR PROVIDER MUST WRITE TO OUT-OF-STATE PRIOR AUTHORIZATION: c/o E.D.S. FEDERAL, 6406 BRIDGE RD. SUITE 88, MADISON, WI. 53784-0088

STATE OF WISCONSIN
MEDICAL ASSISTANCE PROGRAM
IDENTIFICATION CARD
L0018456

APPENDIX 5
Wisconsin Medicaid
Physician Certification/Recertification of Terminal Illness
(Keep this information in the recipient's records. Do not send to Wisconsin Medicaid.)

A. Certification Statement

We (or I) certify that _____ is terminally ill with
(Name of Recipient)

_____.
(Description of Disease)

The life expectancy is six (6) months or less, if the disease runs its normal course.

_____
Recipient Medicaid Identification Number

_____ _____
Certification Date Hospice Medical Director or Designee

_____ _____ _____ _____
Certification Date Attending Physician Medicaid Provider Number Date

B. Recertification Statement

I recertify that the above patient is still considered terminally ill with the above-stated disease with a life expectancy of six (6) months or less, if the disease runs its normal course.

_____ _____ _____
Recertification Date Hospice Medical Director or Designee Date

APPENDIX 6
Wisconsin Medicaid
Notification of Medicaid Hospice Benefit Election Form

(Forward this form to the Medicaid fiscal agent at the address below.)

Part A. **(Complete for all recipients electing hospice.)**

_____ has elected to receive Medicaid hospice benefits.
(Recipient Name)

The recipient signed the Medicaid election form on _____ and has been certified by a physician as having six (6) months or less life expectancy if illness follows its usual course. Hospice has form on file.
(Date)

Do not send to Wisconsin Medicaid.

Name of hospice: _____

Hospice Medicaid provider number: _____

Name of attending physician: _____

Attending physician's Medicaid provider number: _____

Is the attending physician employed by the hospice? Yes _____ No _____

Recipient Medicaid identification number: _____

****

Part B. **(Complete if recipient resides in a nursing home [skilled nursing facility (SNF) or intermediate care facility (ICF)] at time of election of hospice benefit.)**

_____ resides in _____
(Recipient Name) (Nursing Home Name)
at _____level of care.

_____and _____are in agreement that
(Hospice Name) (Nursing Home Name)
the hospice shall provide services, and the nursing home shall provide room and board services as defined under COBRA, P.L. 99-272. "Room and board" includes the performance of personal care services, including assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of the resident's room, and supervision and assistance in the use of durable medical equipment and prescribed therapies.

Wisconsin Medicaid will reimburse the hospice for room and board at 95% of the nursing home's current SNF and ICF 1 & 2 blended daily rate, for the appropriate number of days, for the hospice recipient in the nursing home. The hospice will in turn reimburse the nursing home.

The Medicaid provider number of the nursing home is _____.

****

Part C. **(Complete if the hospice recipient enters a nursing home after admission to the hospice.)**

_____ will reside at _____
(Recipient Name) (Nursing Home Name)

_____
(Address of Nursing Home)

as of _____.
(Date)

_____ and _____
(Hospice Name) (Nursing Home Name)

are in agreement that the hospice shall provide services, and the nursing home shall provide room and board as defined under COBRA, P.L. 99-272. "Room and board" includes the performance of personal care services, including assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of the resident's room, and supervision and assistance in the use of durable medical equipment and prescribed therapies.

Wisconsin Medicaid will reimburse the hospice for room and board at 95% of the nursing home's current SNF and ICF 1 & 2 blended daily rate, for the appropriate number of days, for the hospice recipient in the nursing home. The hospice will in turn reimburse the nursing home.

The Medicaid provider number of the nursing home is _____.

****

Part D. **(Complete for revocation of Medicaid hospice benefits.)**

_____ has decided to discontinue the Medicaid hospice benefit.
(Recipient Name)

The recipient signed the Medicaid revocation form on _____.
(Date)

Name of hospice: _____

Hospice Medicaid provider number: _____

Name of attending physician: _____

Attending physician's Medicaid provider number: _____

Is the attending physician employed by the hospice? Yes _____ No _____

Recipient Medicaid identification number: _____

****

Mail to: Recipient Services
EDS
PO Box 6678
Madison, WI 53716

Appendix 7
Wisconsin Medicaid
Recipient Election of Medicaid Hospice Benefit Form

(Keep this information in the recipient's records. Do not send to Wisconsin Medicaid.)

Name of hospice: _____ Medicaid provider number: _____

I_____, choose to receive hospice care from

_____hospice program. I acknowledge/understand the following:

1. I understand that the hospice program is palliative, not curative, in its goals. This means that the program does not attempt to cure disease, but emphasizes the relief of symptoms such as pain, physical discomfort, and emotional stress that may accompany a life-threatening illness.
2. By choosing Medicaid hospice benefits, I am giving up payment for other service benefits. Only the hospice program will be able to receive Medicaid reimbursement for most services. Medicaid will reimburse separately for covered physician services provided by my attending physician.
3. I can choose to discontinue hospice care at any time. To discontinue, I must complete a revocation statement. I can obtain this statement from the hospice coordinator.
4. If I choose to withdraw from my Medicaid hospice benefit in the middle of a benefit period, I understand that I may re-elect hospice at a later time.
5. I can choose to receive hospice care from another hospice program at any time during the hospice benefit period. To change programs, I must first confirm that the hospice I wish to be admitted to can admit me and on what date.

   I must inform _____of my wishes so
   (Name of Hospice)

   arrangements for transfer can be made. I must document the date I wish to discontinue care from

   _____, the name of the hospice from which I wish to receive care,
   (Name of Hospice)

   and the date that care will start. No benefit days will be lost by changing to another hospice program.

ACKNOWLEDGING AND UNDERSTANDING THE ABOVE, I AUTHORIZE _____
(Name of Hospice)

HOSPICE TO BEGIN PROVIDING MEDICAID COVERED SERVICES ON _____.
(Month/Day/Year)

I DESIGNATE _____ AS MY ATTENDING PHYSICIAN.

_____ _____
Recipient Name Printed/Typed Witness Name Printed/Typed

_____ _____
Signature of Recipient or Legal Representative/Date Witness Signature/Date

APPENDIX 7A
Medicaid Hospice Benefit Revocation (Nonrecertification)/Voluntary Discharge

(Keep this information in the recipient's records. Do not send to Wisconsin Medicaid)

I, _____, **(check one of the following)**
(Recipient Name)

☐ understand that my attending physician and the Hospice Interdisciplinary Team have determined that at this time I do not meet the Medicaid criteria for hospice benefit. The basis for this has been explained to me.

☐ choose to revoke election for Medicaid coverage for hospice care provided by

_____.
(Name of Agency)

Hospice services coverage will continue through _____. Medicaid
(Date)
hospice reimbursement will continue through _____.
(Date)

1. I understand I am revoking Medicaid hospice benefits for the remainder of the current period. I am in the _____Medicaid hospice benefit period. I am forfeiting the remaining _____ days left in this period.
2. If it is determined that I once again meet the Medicaid criteria for the hospice benefit, I can elect Medicaid hospice coverage for the remaining benefit periods checked below:
   _____ Second Benefit Period – 90 days
   _____ Ongoing Benefit Period – 60 days
3. I have used the Medicaid benefit for a total of _____ days.
4. I understand that the Medicaid health care benefits I waived to receive Medicaid hospice coverage will resume _____ (the day following the last day of hospice coverage.
   (Date)
5. I do/do not **(circle one)** waive the fourteen (14) day waiting period required by the State of Wisconsin for voluntary discharge for _____.
   (Name of Agency)

_____
Signature of Recipient of Legal Representative Date

_____
Signature of Hospice Representative Date

APPENDIX 8

WMAP ALLOWABLE REVENUE CODES FOR HOSPICE CARE

The following are the only WMAP allowable revenue codes and descriptions for Hospice Care Services to be billed on the UB-82 claim form.

Revenue Code	Description	Interval	Billing Increment
651	Routine Home Care	< 8 hours in a 24-hour period	per diem
652	Continuous Home Care	8-24 hours	hourly rate
655	Inpatient Respite Care	day	per diem
656	General Inpatient Care	day	per diem
169	Room and Board for SNF/ICF resident	day	per diem
001	Total Charges		

Refer to Appendix 9 for a list of HCPCS procedure code ranges for physician services to be billed on the National HCFA 1500 claim form. Complete codes and descriptions are contained in the Physician's Current Procedural Terminology, Edition 4 (CPT-4) book.

APPENDIX 9
COVERED PHYSICIAN SERVICES FOR HOSPICE RECIPIENTS

Physician Service	CPT Code Ranges
Surgery	10000 – 69979
Radiation Therapy	77261 – 77799
	79000 – 79999
Office Visits	99201 – 99215
Home Visits	99341 – 99353
Hospital Visits	99221 – 99238
SNF Visits	99301 – 99313
ER Department Visits	99281 – 99285
Consultations	99241 – 99245
Unlisted – Misc.	99499
Infusion Therapy	90780 – 90781
Injections	90782 – 90799
Psychiatry	90801 – 90899
Biofeedback	90900 – 90915
Dialysis	90935 – 90999
Gastroenterology	91000 – 91299
Ophthalmology	92002 – 92287, 92499
Contact Lens/Spectacles	92310 – 92396
Otorhinolaryngological	92502 – 92547
Audiology	92551 – 92599
Cardiovascular	92950 – 93960
Pulmonary	94010 – 94799
Allergy	95000 – 95199
Neurology	95819 – 95999
Chemotherapy Administration	96500 – 96549
Dermatology	96900 – 96999
Physical Medicine (Therapy)	97010 – 97799
Special Services and Reports	99000 – 99090
Anesthesia	99100 – 99140
Prolonged Services and Critical Care	99150 – 99199

Allowable procedures within these HCPCS code ranges may be billed by the hospice or attending physician for any hospice recipient, whether or not that physician is employed by the hospice. These services will be paid in accordance with the most recent maximum allowable fees established for these services. These services must be billed by the hospice or attending physician using TOS H in order to be exempt from prior authorization and recipient copayment.

APPENDIX 10

ROUNDING GUIDELINES

The following chart illustrates the rules of rounding and gives the appropriate billing unit(s):

Time (in Minutes)	Unit(s) Billed
1 – 30	.5
31 – 44	.5
45 – 60	1.0
61 – 74	1.0
75 – 90	1.5
91 – 104	1.5
105 – 120	2.0
121 – 134	2.0
etc.	

APPENDIX 11
Additional Services for Hospice Recipients

This appendix presents guidelines for claims submitted for services other than hospice services and allowed attending physician services. The Wisconsin Medicaid consultant will only approve services unrelated to the terminal illness that are otherwise covered benefits of the Wisconsin Medicaid program and are medically necessary.

Provider Category	Claims Deny	Fail to Review	Claims Pay
Ambulatory surgical center			Yes
Attending physician	If type of service "H" is not indicated as the referring physician.	All services not listed in Appendix 9.	All services listed in Appendix 9.
Audiology			Yes
Case management	Yes		
Chiropractor			Yes
Community support program			Yes
Community care organization	Yes		
CRNA		Yes	
Dentist			Yes
ESRD			Yes
Family planning, PNCC	Yes		
HealthCheck	Yes		
Hearing instrument specialist			Yes
Home health	Yes		
ICF/MR	Yes		
IMD	Yes		
Inpatient hospital	Yes		
Lab			Yes
Medical vendor			Yes
Medical day treatment			Yes
Nursing facility	Yes		
Optometrist, optician			Yes
Other physicians	If primary attending physician is not indicated as the referring physician.	All services.	
Outpatient hospital		Yes	

Provider Category	Claims Deny	Fail to Review	Claims Pay
Outpatient mental health/substance abuse (alcohol and other drug abuse)			Yes
Pharmacy	Therapeutic class listed		Yes
Physician services		Yes	
Podiatrist			Yes
Portable X-ray			Yes
Rehabilitation agency/ therapies	Yes		
School-based services	Yes		
Transportation			Yes